

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 54a

CERTIFICATE OF DEATH

Reg. Dist. No. **4336**

1. PLACE OF DEATH:

County

Hagerstown

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *30 years.*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry Gordon Allen

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White Married

Fannie Ruth Allen

6.(b) Name of husband or wife

6.(c) If alive, give age *45* years

7. Birth date of deceased (mo., day, yr.)

Aug 12 - 1894

8. AGE:

Years

Months

Days

It less than one day

50

hrs.

min.

9. Birthplace

Hagerstown

(Town, county, and state)

10. Usual occupation

*Conductor**Railroad*

11. Industry or business

*Furniture**James H. Allen Co.**James H. Allen Co.*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-2924

07357

CERTIFICATE OF DEATH

Reg. Dist. No. 235

1. PLACE OF DEATH:

County Wicomico

City or town Shafton - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2

Hospital, Institution, or street address where death occurred:

Shafton - Mandala Road

How long in hospital or institution?

3. (a) FULL NAME

James O. Allen

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Elisia Allen

7. Birth date of deceased (mo., day, yr.)

February 17, 1897

6.(c) If alive, give age 45 years

8. AGE:

Years 48

Months 4

Days 26

If less than one day

hrs. min.

9. Birthplace

Wicomico County, Maryland

(Town, county, and state)

10. Usual occupation

Day laborer

Farm

11. Industry or business

Fred Pock

MOTHER FATHER

12. Name

Bridgetville, Delaware

13. Birthplace

Martha J. Allen

14. Maiden name

Wicomico County, Maryland

15. Birthplace

Ruby Stanley

16. Informant

Shafton, Maryland, R.F.D.

Address

17. Burial Date thereof July 16, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory San Domingos Cemetery

Location Near Shafton, Maryland

18. Funeral director F.J. Trampman and Son

Address Federalsburg, Maryland

19. July 16 1945 Walter G. Mann

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Wicomico

City or town Shafton - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Shafton - Mandala Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

218-14-2527

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 13 1945 at 10:45 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 1945 to July 13 1945
and that I last saw him alive on July 12 1945

Immediate cause of death

Cerebral Hemorrhage DURATION 24 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

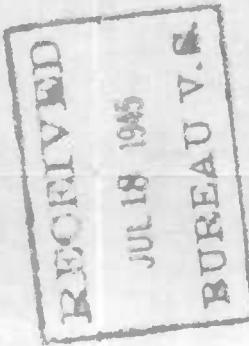
23. SIGNATURE

M. D. or other

Address

Date signed

Signature H.S. Kuhlyman



67358

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County

City or town Sabiney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yearsHospital, institution, or street address where death occurred: RD. #4 (Mt. Vernon Rd)

How long in hospital or institution?

3. (a) FULL NAME

Ruth Elizabeth Blackmon

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

female

White

Married

Richard Blackmon

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

69 years

deceased (mo., day, yr.)

Sept. 18-1876

8. AGE: Years

Months

Days

If less than one day

8. AGE:

Years

Months

Days

hrs.

min.

68

9

13



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Hamon

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

07359

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Nicomis
 County: Salisbury
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution or street address where death occurred: P.B. Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: MD County: Nicomis
 City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 1025 Tallyn, st
 (If rural, give LOCATION)

2.(a) If veteran, name war:

2.(b) Social Security Number

3. (a) FULL NAME Ernest Blades

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

7. Name of husband or wife Minnie Blades

7. Birth date of deceased (mo., day, yr.) Feb. 18-1878 6. (c) If alive, give age 60 years

8. AGE: Years 67 Months 4 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Northeast C. Rd. Precomoke Md. (Town, county, and state)

10. Usual occupation House Painter

11. Industry or business Taundor Blades

FATHER 12. Name R.D. Precomoke Md.

MOTHER 13. Birthplace Airstha Davis

14. Maiden name R.D. Precomoke Md.

15. Birthplace M. Randall S. Blades

16. Informant W. Randall S. Blades

Address P.O. #2 Noroton Pa.

17. Burial Parson Cemetery Date thereof July 18-1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parson Cemetery

Location Salisbury Maryland

18. Funeral director Hollingsworth & Walter P. Hollingsworth

Address Salisbury Maryland

19. (Date rec'd by registrar) 7/17/45 Health Department Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 15 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10 1945 to July 15 1945

and that I last saw him alive on July 9 1945 1945

Immediate cause of death CORONARY Occlusion, Acute

Due to CORONARY Sclerosis

DURATION

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please, underline the cause to which death should be charged statistically.

28. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

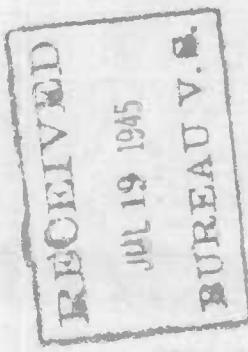
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury None Injured at work?

23. SIGNATURE J. Rivers Hanson, M.D. M. D. or other

Address Salisbury Maryland Date signed 7/17/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13D

CERTIFICATE OF DEATH

67360

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
 County.....
 City or town..... Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since April 2, 1940
 Hospital, Institution, or street address where death occurred: E. Shore Tuberculosis Sanatorium
 How long in hospital or institution? Since April 2, 1940

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Queen Anne
 City or town..... Chester, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

3. (a) FULL NAME
 Bradshaw, Rachel
 4. Sex Female Color or race White 5. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife John C. Bradshaw
 7. Birth date of deceased (mo., day, yr.) December 21, 1867
 8. AGE: Years Months Days If less than one day
 77 7 10 hrs. min.
 9. Birthplace Tylerton, Maryland
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business
 FATHER 12. Name Steward H. Evans
 13. Birthplace Tylerton, Maryland
 MOTHER 14. Maiden name Rachel Evans
 15. Birthplace Tylerton, Maryland
 16. Informant Edison Bradshaw
 Address Chester, Md
 17. Burial Cemetery Date thereof AUG - 3, 1945
 (Burial, cremation, or removal. Which?) Cemetery or crematory Crisfield Cemetery
 Location Crisfield Maryland
 18. Funeral director H. Harry Bradshaw
 Address Crisfield, Maryland
 19. S/1/1945 Margaret E. Johnson
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number
 None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 45, at 9:50p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1940 19, to 7/31/45 19,

and that I last saw her alive on 7/31/45 19.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

8 yr

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

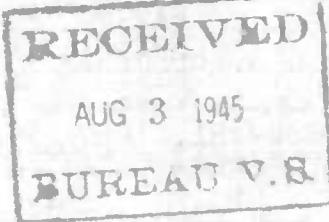
Means of injury

Injured at work?

23. SIGNATURE

Paul E. Johnson M.D. or other

Date signed 8/1/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 40

07361

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

109 W. Phila. ave.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female White Widow

6. (b) Name of husband or wife

Begon N. Buttingham

7. Birth date of deceased (mo., day, yr.)

March 9-1872

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
73 4 10 hrs. min.

9. Birthplace

Salisbury Maryland

(Town, county, and state)

10. Usual occupation

House wife

at home

11. Industry or business

John J. Baker

12. Name

Bethel Delaware

13. Birthplace

Maria Middleton

14. Maiden name

R.D. Parsonburg Md.

15. Birthplace

Mrs. Esther B. Bedeworth

16. Informant

109 W. Phila. ac. Salisbury Md.

Address

Burial, cremation, or removal, Which?

Cemetery or crematory

Location

Hollings & Co. Walter P. Hollings

18. Funeral director

Address

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEDENT:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 19th 1945 at 7 P.M.

2d. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1945 to July 18, 1945, and that I last saw her alive on July 18, 1945

Immediate cause of death

Hodgkin's disease of liver
& metastases

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

2d. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

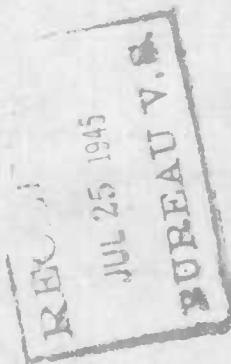
23. SIGNATURE

H. D. or other

Address

Date signed

7/21/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

67362

CERTIFICATE OF DEATH

Reg. Dist. No. 338

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

5 hours

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?.....

5 hours

3. (a) FULL NAME

Louise Frances

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Worcester

City or town.....

RURAL

Poconoske City

Street No.....

R.F.D # 2

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

Brittingham

MEDICAL CERTIFICATION

11:30 A

July 13th 1945 11:30 A

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female Colored Married
Lloyd Brittingham

6.(b) Name of husband or wife.....

58 years

7. Birth date of deceased (mo., day, yr.)

July 4, 1900

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

45

0

9

hrs.

min.

9. Birthplace.....

RURAL, Poconoske - Worcester, Md.
(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

12. Name.....

Gwinell Dennis

13. Birthplace.....

Rural, Poconoske, Md.

14. Maiden name.....

Munil C. Fisher

15. Birthplace.....

Rural, Poconoske, Md.

16. Informant.....

Mrs. Samuel Bacon

Address.....

506 Young St. Poconoske Md.

17. Burial.....

Burial Date thereof July 16 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

St. James Cemetery

Location.....

Rural, Poconoske, Md.

18. Funeral director.....

H. Harvey Bradshaw

Address.....

401 Market St. Poconoske Md.

19. Date rec'd by registrar.....

July 18 1945

Registrar

SIGNATURE

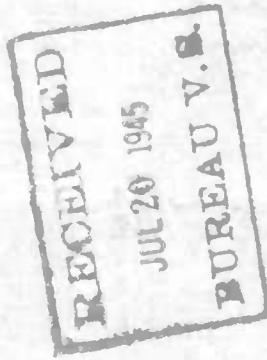
John L. Riley

Dr. M. D. or other

Snow Hill Md.

Date signed

7/14/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Md.*

67363

CERTIFICATE OF DEATH

Reg. Dlat. No. 3.33

1. PLACE OF DEATH:

County

*Salisbury*City or town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

223 E. Batalla, str.

How long in hospital or institution?

3. (a) FULL NAME

Charles Edward Calloway

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**White**Married*

6. (b) Name of husband or wife

Nancy Jane Calloway

7. Birth date of deceased (mo., day, yr.)

June 20 - 1857

8. AGE:

Years

Months

Days

If less than one day

*88**0**25*

hrs.

min.

9. Birthplace

Salisbury Maryland

(Town, county, and state)

10. Usual occupation

Miller

11. Industry or business

Benjamin Calloway

MOTHER FATHER

12. Name

Sussex Co. Del.

13. Birthplace

Hastings

14. Maiden name

Sussex Co. Del.

15. Birthplace

Hastings

16. Informant

M. Benjamin R. Calloway

Address

East Salisbury One Home, Salisbury Md

17. Burial

Buried

Date thereof (month) (day) (year)

Cemetery or crematory

Parkside Cemetery

Location

Salisbury Maryland

18. Funeral director

W. L. Weller R. Weller R. Weller

Address

Salisbury Maryland

19. Date rec'd by registrar

7/17/55

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. Nicomil

City or town

Salisbury

Street No.

223 E. Batalla, st.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 15 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1945 to July 15 1945

and that I last saw him alive on

June 30 1945

Immediate cause(s) of death

Valvular Heart Disease

Due to

Due to

Other conditions *Hypertrophy, Purulent Ulceration*

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

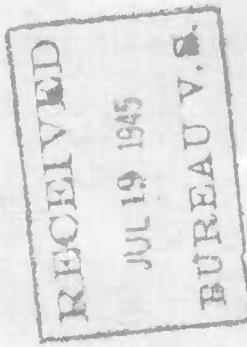
Frances R. Mann

M. D. or other

Address

Salisbury 7th

Date signed



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 921

CERTIFICATE OF DEATH

67364
333
25B

Reg. Dist. No.

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Joshua Alvin Chance

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

wife

married

6. (b) Name of husband or wife

Kathie M. Chance

7. Birth date of deceased (mo., day, yr.)

8. AGE:	Years	Months	Days	If less than one day
	53	7		hrs. min.

8. Birthplace

Queen Anne's County
(Town, county, and state)

10. Usual occupation

retired stockkeeper

11. Industry or business

12. Name

Joshua S. Chance

13. Birthplace

Queen Anne's County

14. Maiden name

Kate McLean

15. Birthplace

Queen Anne's County

16. Informant

Mrs. Kathie Chance

Address

130 Truth St.

17. Burial

Date thereof July 15-1945
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Centreville Cem.

Location

Centreville, Md.

18. Funeral director

Edgar L. Lane

Address

Church Hill Rd.

19. Date rec'd by registrar

July 17-1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 130 Truth St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/13 1945 at 7a M

7/10 1945 to 7/13 1945

and that I last saw him alive on

7/10 1945 1945

Immediate cause of death

Heart Disease DURATION Weeks

Due to

Due to

Other conditions

Angina DURATION Year

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

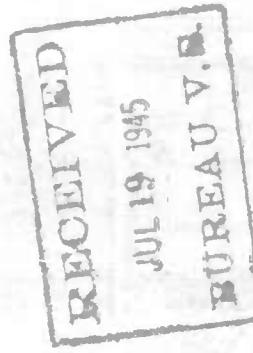
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James R. Mann M. D. or otherAddress Salisbury, Md. Date signed 7/13/45



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1202

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Chelton, Mrs Edith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Widowed

6. (b) Name of husband or wife

Joseph Chelton

7. Birth date of deceased (mo., day, yr.)

Nov. 6, 1864

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day hrs. min.
78	8	16	

9. Birthplace

Somerset Co. Md

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Unknown

12. Name

Unknown

13. Birthplace

Id

14. Maiden name

Bassman

15. Birthplace

Id

16. Informant

Mrs. Marie Elliott

Address

Severna Park

17. Burial

Date thereof July 26, 1945
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Presbyterian

Location

Princess Anne

18. Funeral director

Harry B. Miles

Address

Upper Fairmount

19. Date rec'd by registrar

7/26/45

19. Date signed

John B. Belsham Jr.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County SomersetCity or town Fairmont (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION) _____

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22 1945 at 7:45 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-19 1945, to 7-22 1945 and that I last saw her alive on 7-22 1945

Immediate cause of death

acute gastroenteritis DURATION 4 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations No

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of No

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

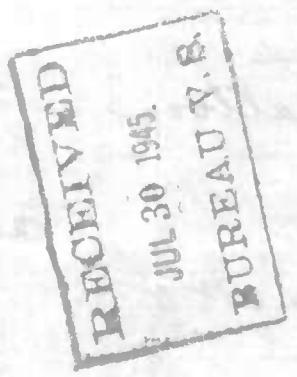
Means of Injury

Injured at work?

23. SIGNATURE John Blackmer M.D.

M. D. or other

Address Baltimore Md Date signed 7/26/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1226

CERTIFICATE OF DEATH

07366

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

T

VS A15

1. PLACE OF DEATH: Hippocies
County: Salisbury

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: General Hospital

How long in hospital or institution? 2 days

3. (a) FULL NAME

Dorothy Cayne4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Maid6.(b) Name of husband or wife: Cayne deceased7. Birth date of deceased (mo., day, yr.) Nov. 27, 1907 6.(c) If alive, give age 80 years8. AGE: Years 80 Months 7 Days 27 If less than one day hrs. 0 min. 09. Birthplace: New York (Town, county, and state) New York10. Usual occupation: Housewife11. Industry or business: None12. Name: James J. Keane13. Birthplace: East Orange, New York14. Maiden name: Edel Seigel15. Birthplace: New York16. Informant: Patsy S. SchellieAddress: 1347 Clinton St., Buffalo, N.Y.17. Burial, cremation, or removal: Burial Date thereof: 7/10/45 (month) (day) (year)Cemetery or crematory: St. Matthew'sLocation: West Street, New York18. Funeral director: De Kell & Green Co.Address: Salisbury, Md.19. (Date read by registrar) 7/13/45 Harriet E. Johnson Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New York County: ErieCity or town: Buffalo (If outside city or town limits, write RURAL and give nearest town)Street No. 71 Sherry St. (If rural, give LOCATION)2.(a) If veteran, name war: ✓3. (b) Social Security Number ✓

MEDICAL CERTIFICATION

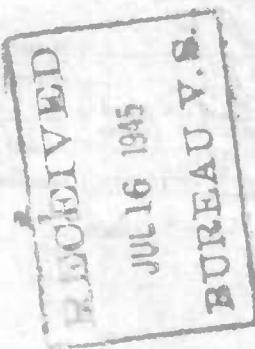
20. DATE OF DEATH: July 17, 1945 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 16, 1945, to July 12, 1945and that I last saw her alive on July 12, 1945Immediate cause of death: StrokeDue to: Thrombosis & obstruction of uterusDue to: 1 dayDuration: 1 hr.Other conditions: (Include pregnancy within 8 months of death)Major findings or operations: Bronchitis of 3 feetDate of op.: July 12, 1945Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NoAccident, suicide, or homicide: none Date of: noneWhere did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) noneMeans of injury falling Injured at work? none23. SIGNATURE: Easton M.D.M. D. or other: Johnson Address: Salisbury, Md. Date signed: 7/12/45



RECEIVED
AUG 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

CERTIFICATE OF DEATH

07368

Reg. Dist. No. 333

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

P. S. Hospital

How long in hospital or institution?

3. (a) FULL NAME

Thurman Thorne Dennis

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White married

Elizabeth Dennis Dennis

6.(b) Name of husband or wife

6.(c) If alive, give age

37 years

7. Birth date of deceased (mo., day, yr.)

July 17, 1905

8. AGE:

Years

Months

Days

If less than one day

40

6

2

hrs.

min.

9. Birthplace

Willard, Wisconsin, MD

(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

Liquor Dispensary

MOTHER FATHER

12. Name

John Murray Dennis

13. Birthplace

Wisconsin, MD

14. Maiden name

Ella M. Thorne

15. Birthplace

Wisconsin, CA, MD

16. Informant

Mrs. Thurman H. Dennis

Address

Pittsville, MD

17. Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Pittsville Cemetery

Location

Pittsville, MD

18. Funeral director

The Hill & Johnson Co.

Address

Salisbury, MD

19. (Date rec'd by registrar)

1945 - Bassett & Johnson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Wisconsin

City or town

Pittsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

216-07-2101

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 19, 1945, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from

July 19, 1945, to July 19, 1945, and that I last saw him/her alive on July 19, 1945.

Immediate cause of death

Coronary Thrombosis

DURATION

Several

Due to

Due to

Other conditions

C. Reinholt

(Include pregnancy within 8 months of death)

Major findings of operations

July 19, 1945

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

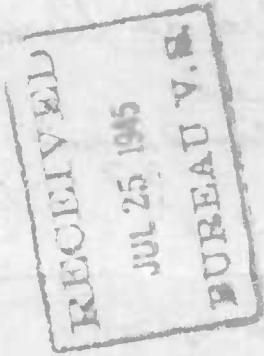
23. SIGNATURE

John Web

M. D. or other

Address

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *R&O*

07369

Reg. Diat. No. 333

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County *Wicomico*
City or town *Habisham*

How long in above place of death?

Hospital or Institution, street address where death occurred:
P.S. Hospital

How long in hospital or institution?

3. (a) FULL NAME

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widow*

6. (b) Name of husband or wife *James L. Derrickson*

7. Birth date of deceased (mo., day, yr.) *Nov. 5 - 1861* 6. (c) If alive, give age *Dead* years

8. AGE: Years *83* Months *7* Days *27* If less than one day hrs. min.

9. Birthplace *Roxanna Delaware* (Town, county, and state) *Home wife*

10. Usual occupation *Home wife*

11. Industry or business *William at Home*

MOTHER FATHER 12. Name *William Derrickson*

13. Birthplace *Roxanna Delaware*

14. Maiden name *Elijah B. Morris*

15. Birthplace *Roxanna Delaware*

16. Informant *W. William Derrickson*

Address *Paramount Md.*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *July 5-45* (month) (day) (year)

Cemetery or crematory *Roxanna Cem.*

Location *Roxanna Delaware*

18. Funeral director *Holloway & Walter R. Holloway*

Address *Saltby Maryland*

19. (Date feed by registrar) *7/6/45* 19..... Registrars Address *John W. Johnson*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State *Delaware* County *Sussex*
City or town *Frankford*

Street No. *Knox Street* (If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 2nd 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 20 1945* to *July 2 1945*, and that I last saw him *alive* on *July 2 1945*.

Immediate cause of death *Ch. Dat. Heart -*

Due to *Ch. Dat. Heart -*

Due to *Ch. Dat. Heart -*

Other conditions *Fractured Jy.*

Due to *Fractured Jy.* (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *June 1st 1945*

Where did injury occur? *Habisham's* (City or town) *Wicomico* (County) *Maryland* (State)

Injured at home, farm, industry, public place (where?) *At home*

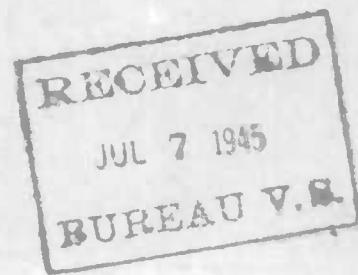
Means of Injury *Accidental fall* Injured at work?

23. SIGNATURE *W. O. Davis M.D.*

M. D. or other

Date signed *7/6/45*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1945

CERTIFICATE OF DEATH

07370

Reg. Dist. No. 333

1. PLACE OF DEATH:
County. *Womack*

City or town. *Selbyville, Md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 6 hr*

Hospital, Institution, or street address where death occurred:

Penninsula General Hospital

How long in hospital or institution? *3 6 hours*.

3. (a) FULL NAME

Dew, Jessie Jr.

4. Sex	5. Color or race	6. (u) Single, married, widowed, or divorced
<i>m</i>	<i>col</i>	<i>Single</i>

6. (b) Name of husband or wife. *✓*

7. Birth date of deceased (mo., day, yr.) *July 1 1945*

6. (c) If alive, give age *1 year*

8. AGE: Years	Months	Days	If less than one day
<i>1</i>	<i>5</i>	<i>22</i>	<i>- hrs. — min.</i>

9. Birthplace. *Delaware*
(Town, county, and state)

10. Usual occupation. *Layabout (None)*

11. Industry or business. *✓*

FATHER	12. Name.
	<i>Jessie Dew Sr</i>

MOTHER	13. Birthplace
	<i>Delaware</i>

MOTHER	14. Maiden name
	<i>Lucie Sawyer</i>

MOTHER	15. Birthplace
	<i>Delaware</i>

16. Informant. *Lucie I Dew*

Address *Lucie I Dew Rd 2*

17. Burial, cremation, or removal? *Burial* Date thereof *July 19 1945*
(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory *Sydenham Cemetery*

Location *Thetford, Md. 1810*

18. Funeral director *J. Harvey Williamson*

Address *Tuckahoe, Md*

19. (Date filed by registrar) *7/29 1945* *Haggette Johnson*
Registrar *J. Haggette Johnson*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State. *Delaware* County. *Sussex*

City or town. *Laurel PFD #3*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *—*
(If rural, give LOCATION)

2. (u) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH *7-26* 1945 at 9:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive *at 9:45 p.m.* 1945 to 1945

Immediate cause of death

strychnine poisoning DURATION *36 hrs*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations. *None*

Date of op.

Autopsy results. *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. *accident* Date of *7-25-45*

Where did injury occur? *Laurel PFD #3* County *Sussex* State *Del*

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *None*

Means of Injury *Brok by accidt* Injured at work? *No*

23. SIGNATURE *Johnson* M. D. or other *Physician*

Address *Laurel Del* Date signed *7-26-45*

RECEIVED

AUG 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92-b

07371

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Wicomico*
County *Salisbury*

City or town *Salisbury* (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *4 months*

Hospital, Institution, or street address where death occurred:
312 Smith st

How long in hospital or institution?

3. (a) FULL NAME *Margaret O. Dushawon*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *July 9th 1887* 8. (c) If alive, give age *years*

8. AGE: Years *58* Months *6* Days *21* If less than one day *hrs. min.*

9. Birthplace *Salisbury Maryland* (Town, county, and state)

10. Usual occupation *at Drpt. store*

11. Industry or business *Mathilda Dushawon*

MOTHER FATHER 12. Name *Mathilda Dushawon*

13. Birthplace *Allen Maryland*

14. Maiden name *Ellen Hayman*

15. Birthplace *Somerset Co. Maryland*

16. Informant *Mrs. George R. Gilmer*

Address *312. Smith st. Salisbury Md.*

17. Burial *Buried* Date thereof *Aug 10th 1945* (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Parsons Cemetery*

Location *Salisbury Maryland*

18. Funeral director *Holloway & Co. Walter P. Holloway*

Address *Salisbury Maryland*

19. *8/10/1945 - Hospital* (Date rec'd by registrar) S. I. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Wicomico*

City or town *Salisbury* (If outside city or town limits, write RURAL and give nearest town)

Street No. *312 Smith street* (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 31st 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 10 1945 to *July 31 1945*

and that I last saw her *alive* on *July 31 1945*

Immediate cause of death

Pulmonary Edema, Heart Disease

Due to *Myocarditis*

Due to *Rheumatic Heart Disease*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations *none*

Date of op.

Autopsy results *none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *none* Date of *none*

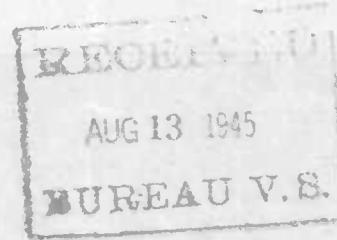
Where did Injury occur? *(City or town)* *(County)* *(State)*

Injured at home, farm, industry, public place (where?)

Means of Injury *none* Injured at work? *none*

23. SIGNATURE *L. Hayes Hanson M.D.* M. D. or other

Address *Salisbury, Md* Date signed *8/14/45*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

07372

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, Institution, or street address where death occurred:

Peninsula General Hos.How long in hospital or institution? 15 days

3. (a) FULL NAME

Mr. Thomas Donoway4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Doris Donoway7. Birth date of deceased (mo. day, yr.) Dec. 25, 1877 6. (c) If alive, give age 75 years8. AGE: Years 67 Months 6 Days 10 If less than one day hrs. min.9. Birthplace Wheaton, W. Va. Md.
(Town, county, and state)10. Usual occupation Carpenter & Barber

11. Industry or business

12. Name George S. Donoway13. Birthplace Md.14. Maiden name Annie Adkins15. Birthplace Md.16. Informant Mr. Thomas DonowayAddress Pawtucket Md.17. Burial Burial Date thereof 9/8/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. JohnsLocation Pawtucket Md.18. Funeral director Annie S. BurbridgeAddress Berlin Md.19. 7/8/45 1945 Death of John
(Date read by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Pawtucket
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5 19 45 at 10:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/20/45 to 7/5/45 19 to 19and that I last saw him alive on 7/5/45 19

Immediate cause of death

Cardiac Arrest

Due to _____ DURATION _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations Cyst Date of op. 9/25/45

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work?

23. SIGNATURE John Sch

M. D. or other

Address Wells Date signed 7/11/45

RECEIVED

JUL 11 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B.B.)

67573

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH: Wicomico
 County.....
 City or town..... Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? June 6, 1945
 Hospital, institution, or street address where death occurred: E. S. Tb. Sanatorium
 How long in hospital or institution? Since June 6, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Somerset
 City or town..... Crisfield, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 23 Baltimore Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

3. (a) FULL NAME

Evans, Ernest Carroll

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Phoebe Evans
 7. Birth date of deceased (mo., day, yr.) Sept 20, 1890
 8. (c) If alive, give age..... 47 years

8. AGE: Years	Months	Days	If less than one day
54	9	26	hrs. min.

9. Birthplace..... Crisfield, Maryland
 (Town, county, and state)

10. Usual occupation..... Supt. Ship Yard

11. Industry or business

FATHER 12. Name..... Lewis Stewart Evans
 13. Birthplace..... Maryland

MOTHER 14. Maiden name..... Mary Ann Riggan
 15. Birthplace..... Maryland

16. Informant..... Mrs. Phoebe Evans
 Address..... Crisfield, Md.

17. Burial..... Date thereof..... 7/18/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Sunny Ridge

Location..... Crisfield, Md.
 Funeral director..... Howard H. Hubbard

Address..... 506 Main St., Crisfield, Md.

Date rec'd by registrar..... 7/17/45 19..... C. E. Collins, M.D.
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 16 1945 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/16/44-11/24/44 19..... to 6/6/45 7/16/45 19..... and that I last saw h. i. m. alive on 7/16/45 19.....

Immediate cause of death..... Pulmonary Tuberculosis DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Data of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

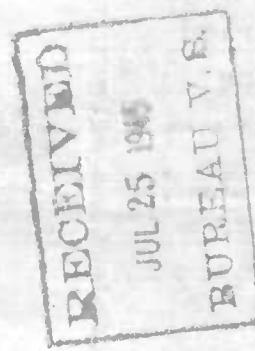
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... Paul G. T. M.D. or other

Date signed..... 7/16/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

17374

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Salisbury MDCity or town Salisbury MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 7 yearsHospital, Institution, or street address where death occurred: noHow long in hospital or institution? no

3. (a) FULL NAME

Bethel Parlowe4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Charles Parlowe6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) yes 18808. AGE: Years 66 Months Days If less than one day hrs. min. 9. Birthplace Parsonberg MD

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Same as above12. Name Sonnie West13. Birthplace Parsonberg MD14. Maiden name Maria Bushell15. Birthplace Parsonberg MD16. Informant Charles ParloweAddress Salisbury MD17. Burial Date thereof Buried July 16 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glass HillLocation Parsonberg18. Funeral director James H. StewartAddress Salisbury MD19. (Date read by registrar) 7/17/45 (Signed) J. H. Stewart (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MDCounty WicomicoCity or town Salisbury MD

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Lombard St(If rural, give LOCATION) no2.(a) If veteran, name war no3. (b) Social Security Number no

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 194521. I CERTIFY that death occurred on the date above stated, that I attended deceased from March 10, 1945 to July 12, 1945 and that I last saw her alive on July 11, 1945.Immediate cause of death Pulmonary Tuberculosis

DURATION

Due to Due to Other conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

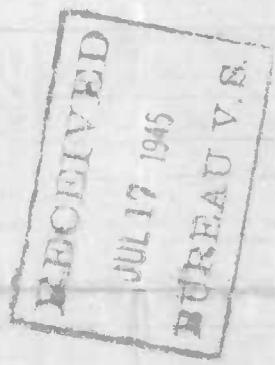
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE J. H. Stewart MD

M. D. or other

Address Salisbury MD Date signed 7/17/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

67375

Reg. Dist. No.

333

1. PLACE OF DEATH:

County.....

Delaware

City or town.....

Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Five days

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?.....

One day

3. (a) FULL NAME

Penelope Gandy

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female and widow

6.(b) Name of husband or wife

Penelope Gandy

7. Birth date of

deceased (mo., day, yr.)

Deceased B.C. If alive, give age 1297 years

about 48

hrs.

min.

8. AGE: Years Months Days

If less than one day

about 48 - -

hrs. min.

about 48 - -

hrs. min.

about 48 - -

9. Birthplace.....

Salisbury, Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

Same as above

12. Name.....

Eunice Berkhead

13. Birthplace.....

Rockawalkin, Md.

14. Maiden name.....

Martha Tides

15. Birthplace.....

Salisbury, Md.

16. Informant.....

Mrs. Martha J. Buckhead

Address.....

Salisbury, Md.

17. Burial.....

Date thereof July 13-1965

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Houston

Location.....

Salisbury, Md.

18. Funeral director.....

James E. Stewart

Address.....

Salisbury, Md.

19. Date record by registrar.....

7/11/65

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. County.....

City or town.....

Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

311 Delaware St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 10 1965

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10 1945 to July 10 1945

and that I last saw her alive on July 10 1945

Immediate cause of death.....

Cerebral hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Person signing in D. M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4B

CERTIFICATE OF DEATH

67376

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Weomis
 City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth J. Hornor4. Sex F 5. Color or race B 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) January 1, 1885 8. (c) If alive, give age _____ years8. AGE: Years 59 Months Days If less than one day hrs. min. 9. Birthplace Eden, Maryland (Town, county, and state)10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER 12. Name John Burday13. Birthplace Eden, Maryland14. Maiden name 15. Birthplace 16. Informant Emily HornorAddress Salisbury, Md.17. Burial Burial Date thereof July 4, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Flowers Hill CemeteryLocation Eden Maryland18. Funeral director White W. MarshallAddress Princess Anne, Md.19. (Date rec'd by registrar) 7/3/45 Registrar J. Johnson

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Weomis
 City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 2, 1945 at 12:30 M
 21. I CERTIFY that death occurred on the date above stated, that I attended deceased from
July 1, 1945 to July 2, 1945 and that I last saw her alive on July 1, 1945

Immediate cause of death

Carcinoma
 Due to Primary carcinoma of uterus. Cura
 Due to Duration two years

DURATION

2 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work? _____

23. SIGNATURE

G. H. Lembly M.D. D. D. or other _____Address Salisbury, Md. Date signed 7/2/45

RECEIVED
JUL 7 1945
BUREAU V.R.

M

1 MARGIN RESERVED FOR BINDING

1

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 892

07378

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Eden*
 County: *Baltimore*
 City or town: *Baltimore* (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, Institution, or street address where death occurred: *82 - Hoyt*

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
 (For newborn infants give residence of mother) *Symmet. Edmund*
 State: *Md.* County: *Eden*
 City or town: *Eden* (If outside city or town limits, write RURAL and give nearest town)
 Street No.: *82* (If rural, give LOCATION)

2.(a) Is veteran, name war?

3. (a) FULL NAME

Nellie Hayman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
Female	White	Widow		
6.(b) Name of husband or wife		Ottis J. Hayman		
7. Birth date of deceased (mo., day, yr.)		Sept. 23-1889		
8. AGE:	Years	Months	Days	If less than one day
	55	9	13	hrs. min.
9. Birthplace		R.O. Eden Md		
(Town, county and state)				
10. Usual occupation				
11. Industry or business				
MOTHER FATHER	12. Name			
	13. Birthplace			
MOTHER	14. Maiden name			
	15. Birthplace			
16. Informant				
Address				
17. Burial				
(Burial, cremation, or removal? Which?)				
Date thereof (month) (day) (year)				
Cemetery or crematory				
Location				
18. Funeral Director				
Address				
19. (Date rec'd by registrar)				

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 6 1945* at *3:20 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 28 1945* to *July 6 1945* and that I last saw her *alive* on *July 6 1945*.

Immediate cause of death *Cerebral Hemorrhage*

Duration *2 hr.*

Due to *Hypertension*

Due to *Arterio - Sclerosis*

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

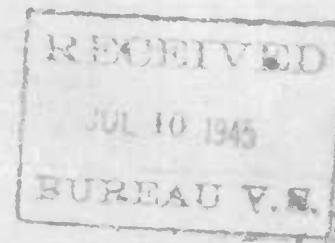
Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Date signed



M

MARGIN RESERVED FOR BINDING

1

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

07379

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Raugh S. Keam

7. Birth date of deceased (mo., day, yr.)

April 22 1906

6. (c) If alive, give age years

40

8. AGE:

Years

Months

Days

If less than one day

39

2

11

hrs.

min.

9. Birthplace

(Town, county, and state)

Chincoteague Va.

10. Usual occupation

Operated at

shirt factory

George & Son

Seaford Del.

Katie Pointer

Chincoteague Va.

M. Raugh S. Keam

127 Dover St, Salisbury Md.

Business

as alone

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature

Address

Salisbury Md.

7/6/45

Date signed

Harrington Johnson

Registrar

Signature

Address

Salisbury Md.

7/3/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

127 Dover Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 3, 1945 al

July 3, 1945, lo. July 3, 1945

and that I last saw her alive on July 3, 1945

Immediate cause of death

Cerebral Hemorrhage
(Rt. Temporal Lobe)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

name

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

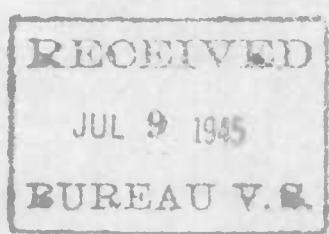
Signature

M. D. or other

Address

Signature

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of sex & color of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

67380

CERTIFICATE OF DEATH

Reg. Diat. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town Dealeville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Arthur Johnson

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Mosie Johnson

7. Birth date of deceased (mo., day, yr.) November 6(c) If alive, give age years

8. AGE: Years 61 Months atay Days If less than one day hrs. min.

9. Birthplace Farmount Somerset Co. Md. (Town, county, and state)

10. Usual occupation seafood worker

11. Industry or business Farm

FATHER 12. Name John Johnson

13. Birthplace Farmount Somerset

MOTHER 14. Maiden name Mosie

15. Birthplace Somerset Co.

16. Informant Mortons Wares

Address Farmount Md.

17. Burial cremation Date thereof 7/31/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Star Funeral

Location Farmount Md.

18. Funeral director Lazarus & Ward

Address Morison Md.

19. Date rec'd by registrar July 30 1945

R. Walford Miller
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Somerset

City or town Farmount (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

219-1X-61151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29

1945 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-28 1945 to 7-29 1945

and that I last saw h. alive on 7-28 1945

Immediate cause of death Acute Pulmonary

edema

DURATION

4-shrs.

Due to Cardiac failure

Due to Rheumatic + Arteriosclerotic
hypertensive heart disease

20 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William V. Lovett Jr. M.D.

M. D. or other

Address Box 12, Alluvial Fields Rd., Farmington, Maryland

Date signed 7-29-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Warner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

07381

CERTIFICATE OF DEATH

Reg. Dlat. No. 333

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution or street address where death occurred:

R.O. #3 (Delmar Road)

How long in hospital or institution?

3. (a) FULL NAME

Amanda Jane Kelley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

White

Married

Charles R. Kelley

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept 19th 1883

Years

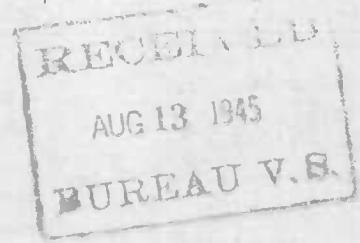
Months

Days

If less than one day

hrs.

min.



PLEASE WRITE PLAINLY, WITH-UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of MARYLAND STATE DEPARTMENT OF HEALTH
usual residence of deceased 2411 N. Charles St., Baltimore 832
is shown on FILM NO. G 97 AUG 20 1945 CERTIFICATE OF DEATH ★

07382

Reg. Dist. No. 335

1. PLACE OF DEATH:

County.....

Delaware

City or town.....

Sharptown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

William J. Kinkin

4. Sex

m White Married

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

Victoria Kinkin

7. Birth date of deceased (mo., day, yr.)

Oct 25 - 1878

8. AGE:

Years 66 Months 8

Days 16 If less than one day

hrs. min.

9. Birthplace.....

Sharptown Del Md

(Town, county and state)

10. Usual occupation.....

Merchant

11. Industry or business

Lewin J. Kinkin

12. Name.....

Lewin J. Kinkin

13. Birthplace

Del

14. Maiden name.....

Nancy E. Graham

15. Birthplace

Del

16. Informant.....

Victoria Kinkin

Address

120 N 3rd St Baltimore

17. Burial

Date thereof 7-15-1945

(month) (day) (year)

(Burial, cremation, or removal. Which)

Cemetery or crematory.....

Taylor

Location.....

Sharptown

18. Funeral director.....

By funeral Bros

Address

Sharptown

19. Date rec'd by registrar.....

Walter G. Mann

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State..... New Jersey County.....

City or town..... Sharptown City of Camden

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

147-12-5858

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 11 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1945 to July 11 1945 and that I last saw him alive on July 11 1945

Immediate cause of death.....

Cerebral Hemorrhage DURATION 6 years

Due to..... Articisclerosis

Due to.....

Other conditions..... Venous Occlusion

2 days

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

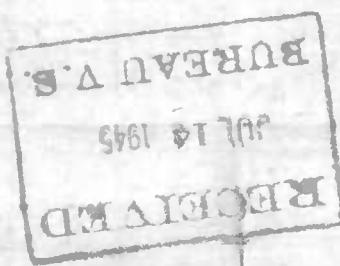
Means of injury.....

Injured at work?

23. SIGNATURE.....

H. S. Kinkin M. D. or other

Address..... Sharptown Md Date signed 7/12/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

07383

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:

County

Waldsmere

City or town

Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 days

Hospital, institution, or street address where death occurred:

no

How long in hospital or institution?

no

3. (a) FULL NAME

Leslie Jane Leonard

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

a.a.

widower

6. (b) Name of husband or wife

John Leonard

7. Birth date of deceased (mo., day, yr.)

dead

6. (c) If alive, give age no years

about 1864

8. AGE:

Years

Months

Days

If less than one day

about 77

—

—

hrs.

min.

9. Birthplace

Salisbury Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Same as above

12. Name

Unknown

13. Birthplace

Assume same

14. Maiden name

Barbara Brewington

15. Birthplace

Salisbury Md

16. Informant

Mr. Stewart Leonard

Address

Salisbury Md

17. Burial

Cremation

Date thereof

July 8-1945
(month) (day) (year)

Cemetery or crematory

Harrison

Location

Salisbury Md

18. Funeral director

James P. Stewart

Address

Salisbury Md

19. (Dated rec'd by registrar)

7/8/45

1945

Received by

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Wicomico

City or town

Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Braida

(If rural, give LOCATION)

2.(a) Is veteran, name war

no

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 4

5

1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 2 1945 to July 5 1945

and that I last saw h.c.y. alive on July 5 1945

Immediate cause of death

Arterio-Sclerosis

DURATION

5 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur L. Brown

M. D. or other

Address

Salisbury Md

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

07384

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Salisbury Nicomis*

County

City or town *Salisbury*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

P.B. Hospital

How long in hospital or institution?

3. (a) FULL NAME *Joyce Ann Lewis*4. SEX *Female*5. Color or race *White*

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *July 4-1945*

6. (c) If alive, give age years

8. AGE: Years *1* Months *1* Days *1*

It less than one day

9. Birthplace *P.B. Hospital, Salisbury Md.*

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name *Roy J. Lewis*13. Birthplace *Salisbury Md.*14. Maiden name *Mellie Ford*15. Birthplace *James Menge Md.*

16. Informant

Address

E. Nicomis St. (Md. & cts) Salisbury
Burial Date thereof *July 7-1995*

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. *Holmes & Co. Walter R. Holmes*

Address

VS A15

Date signed by registrar

19. *7/7/95*

RECEIVED
JUL 11 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Hicomis
 County: Eden
 City or town: Eden
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, Institution, or street address where death occurred:
R.D. #1.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Md. County: Hicomis
 City or town: Eden
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: R.D. #1.
 (If rural, give LOCATION)

3. (a) FULL NAME
Charles Columbus McGee

3. (b) Social Security Number
McGee

4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife: Elsie L. McGee

7. Birth date of deceased (mo., day, yr.): April 23-1886 6. (c) If alive, give age: 40 years

8. AGE: Years: 59 Months: 2 Days: 20 If less than one day: _____ hrs. _____ min.

9. Birthplace: Western Maryland
 (Town, county, and state)
Farmer

10. Usual occupation: Farmer

11. Industry or business: Charles Henry McGee
 Father: Charles Henry McGee

Mother: Frances Rose 12. Name: Charles Henry McGee

Mother: Frances Rose 13. Birthplace: R.D. Georgetown Delaware

Mother: Frances Rose 14. Maiden name: Addie Frances Rose

Mother: Frances Rose 15. Birthplace: Somersett Co. Maryland

Mother: Frances Rose 16. Informant: Mrs. Elsie L. McGee

Address: R.D. #1. Eden, Md. 17. Burial: Burial Date thereof: July 15-43
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory: Shad Point Cem.

Location: Shad Point Md.

Funeral director: Hollings & Co. Walter P. Hollings

Address: Tisbury Maryland

Date record by registrar: 7/15/45 Signature of Registrar: John D. Johnson Seal:

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1943 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 to July 13 1943, and that I last saw him alive on Apr 1st 1943

Immediate cause of death: Chronic myocarditis Duration: 3 yrs

Due to: _____

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: Dr. Wm. H. Johnson M.D. or other: _____ Date signed: July 14

Address: Summer Hill, Suburb



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 426

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 yrs.

Hospital, Institution, or street address where death occurred:

~~3 yrs.~~

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

Ernest F. Mitchell

7. Birth date of deceased (mo., day, yr.)

Oct. 16. 1878

8. (c) If alive, give age

79

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Willards, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Bengie's Dry Goods

FATHER

12. Name

Amelia Dennis

13. Birthplace

Md.

MOTHER

14. Maiden name

Amelia Dennis

15. Birthplace

Md.

16. Informant

Mr. Ernest Mitchell

Willards, Md.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

(monthly) (day) (year)

(Include pregnancy within 8 months of death)

(Major findings of operations)

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Spiegel, M.D.

M. D. or other

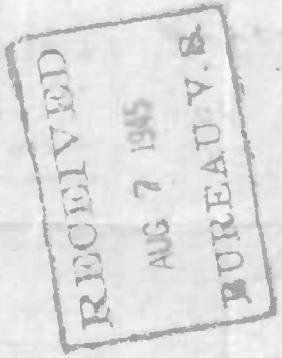
Address

Berlin, Md.

Date signed

7/2/45





~~M~~
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

17387

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wisconsin

City or town Milwaukee

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial General Hospital

How long in hospital or institution? 11 days

3. (a) FULL NAME

Moore, George

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Mrs Julia A. Moore

6. (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.)

Sept 29, 1860

8. AGE:

Years Months Days If less than one day
84 10 2 hrs. min.

9. Birthplace

Porterville, Del.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

Name Daniel Moore

Birthplace Porterville, Del.

Maiden name unknown

Birthplace

Mrs Olive Fields

Address

Hampton, Va.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 3, 1945
(month) (day) (year)

Cemetery or crematory

Asbury Cemetery

Location

Mt Vernon, Md.

Funeral director

Wade Dashwell

Address

Princess Anne, Md.

Date rec'd by registrar

8/9/45

19

45

7

Aug

31

19

45

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wisconsin

City or town Allen, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 - 31

19 45 at RP - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 - 20 19 45 to 7 - 31 19 45

and that I last saw h. m. alive on July 31 19 45

Immediate cause of death

seizure and chronic myocarditis

Due to: with degeneration

DURATION

6 weeks

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

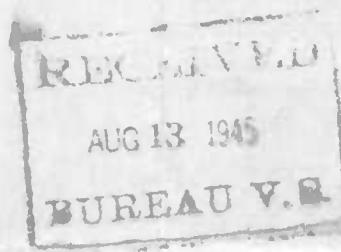
23. SIGNATURE

J. Pademolar MD

M. D. or other

Address 17387 7/31/45

Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. This certificate is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

07388

CERTIFICATE OF DEATH

Reg. Dist. No. 329

1. PLACE OF DEATH:

County Wicomico
 City or town Saboty Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Mumford, Mr John W.4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced MarriedMale white Married8. (b) Name of husband or wife Mumford, Mrs Grace7. Birth date of deceased (mo., day, yr.) April 7, 1877 6. (c) If alive, give age 63 years8. AGE: Years 68 Months 3 Days 16 If less than one day hrs. min.9. Birthplace Newark, Del Co. Md.
(Town, county, and state)10. Usual occupation Retired Barber

11. Industry or business

12. Name Thomas J. Mumford13. Birthplace Maryland14. Maiden name Catherine Nicholson15. Birthplace Wales16. Informant Mrs. John W. MumfordAddress Newark, Del17. Burial, cremation, or removal. Which? Cremated Date thereof 7/25/45
(month) (day) (year)Cemetery or crematory BowmanLocation Newark, Del18. Funeral director Anna R. BarberAddress Berlin, Del19. (Date rec'd by registrar) 7/25/45 19.45 Barbara E. Barber Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Newark (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

7-15 1945 to 7-23 1945
 end that I last saw h. m. alive on 7-22 1945

Immediate cause of death

Hemorrhage peritonitis

DURATION

Due to Hemorrhage ruptured
appendicitis

Due to

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations Gastro peritonitis
sanguous excretions Date of op. 7-15-45Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

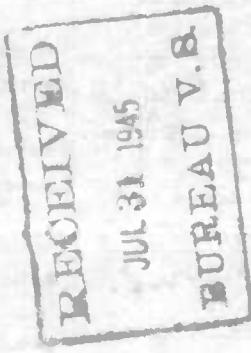
Means of injury

Injured at work?

23. SIGNATURE J. Pademacher MD

M. D. or other

Address Johns Hopkins Hospital, Md Date signed 7/27/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07389

CERTIFICATE OF DEATH

Reg. Dist. No. 337

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS A15

1. PLACE OF DEATH:

County WisconsinCity or town Pewaukee WI

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary E. Mutschler

4. SEX

5. Color or race

6. (a) Single, married, widowed, or divorced

F Married

6. (b) Name of husband or wife

Wm B Mutschler6. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.)

May 22 18768. AGE: Years 69 Months 2 Days 6 If less than one day _____ hrs. _____ min.9. Birthplace Greenwich Conn.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own Home

MOTHER FATHER

12. Name John H. Gally13. Birthplace Ireland14. Maiden name Mary Anne Hamilton15. Birthplace Greenwich Conn.16. Informant Lady MutschlerAddress Pewaukee WI17. Buried Date thereof July 11 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenwich Conn.Location Greenwich Conn.18. Funeral director C. B. MessickAddress Pewaukee WI

19. July 31 1945 P. Wolford Muller

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WICounty WisconsinCity or town Pewaukee WI

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27

1945 at 2:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1st 1945 to July 26th 1945and that I last saw h. alive alive on July 26 1945

Immediate cause of death

Chronic myocarditis

DURATION

Due to

Due to

Other conditions

Atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

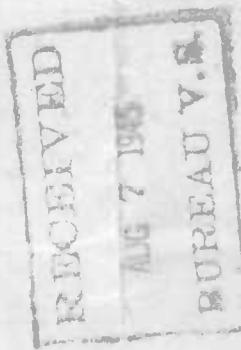
23. SIGNATURE

William Enrich

M. D. October

Address

Hector Rd Date signed July 28-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B76*

CERTIFICATE OF DEATH

07390

Reg. Dist. No. *233*

1. PLACE OF DEATH:

County *Wicomico*City or town *Salisbury*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *4 day - 12 hrs. 50 mins.*

Hospital, Institution, or street address where death occurred:

*Peninsula General Hospital*How long in hospital or institution? *4 day - 12 hrs. 50 mins.*

3. (a) FULL NAME

Padgett, Herman

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

Male Col. Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *1897*

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

48

hrs.

min.

9. Birthplace

Florida

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Same as above

FATHER

12. Name

Unknown

MOTHER

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Taisy Porter

Address

Bishopsville, Maryland

17. Burial

Date thereof

7/27/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Public Cemetery

Location

Salisbury, Maryland

18. Funeral director

J. E. James & Stewart

Address

402 E. Church St. Salisbury, Md.

19. Date rec'd by registrar

19

7/27/48

(Date rec'd by registrar)

7/27/48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Worcester*City or town *Bishopsville*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *no*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

Don't know

MEDICAL CERTIFICATION

20. DATE OF DEATH

*7-24*19 *45* at *7:50 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/19 to *7/24*19 *45*and that I last saw him alive on *7/24*19 *45*

Immediate cause of death

Uraemia, convulsions

DURATION

5 days

Due to

Chronic Nephritis

duration

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. M. Moore

M. D. or other

Address

Salisbury, Md.

Date signed

7/28/48

RECEIVED

AUG 3 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07391

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County..... *Wisconsin*
City or town..... *Salisbury*

(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... *8 Month*

Hospital, Institution, or street address where death occurred:
..... *415 Davis St*

How long in hospital or institution?.....

3. (a) FULL NAME

Wilmer Pallitt

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... Sept 2, 1869
..... (c) If alive, give age years

8. AGE: Years..... 75 Months..... 10 Days..... 21 If less than one day..... hrs..... min.

9. Birthplace..... *Wisconsin Co., Md*
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

MOTHER FATHER
12. Name..... *Andrew Pallitt*

13. Birthplace..... *Wisconsin Co., Md*

14. Maiden name..... *Virginia Anderson*

15. Birthplace..... *Wisconsin Co., Md*

16. Informant..... *Wisconsin Co., Welfare*

Address..... *Salisbury, Md*

17. Burial..... *Burial* Date thereof..... *7/25/41*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Paxtons Cemetery*

Location..... *Salisbury, Md*

18. Funeral director..... *The Hill & Johnson*

Address..... *Salisbury, Md*

19. (Date reg'd by registrar)..... *7/26/46* Registrar..... *John J. Doherty*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... *Md* County..... *Wisconsin*
City or town..... *Salisbury*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *415 Davis St*
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *July 22, 1941*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____
and that I last saw him alive on _____

Immediate cause of death..... *medicinal exam*

Chronic myocarditis; duration one year

with cerebral

decompensation

Due to old age; arteriosclerosis.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... None Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Date of op.

Accident, suicide, or homicide.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

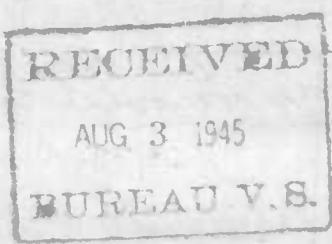
Means of injury.....

Injured at work?

23. SIGNATURE..... *J. H. Doherty, M.D.* M. D. or other.....

Address..... *Salisbury, Md* Date signed..... *7/23/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 372

CERTIFICATE OF DEATH

67392

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....

City or town.....

Wicomico

Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?..... 7/6/45 to 7/7/45

3. (a) FULL NAME

Mr. William Z. Powell

4. Sex.....

Male

5. Color or race.....

White

6.(a) Single, married, widowed, or divorced.....

Married

6.(b) Name of husband or wife.....

Mrs. Mamie Powell

7. Birth date of deceased (mo., day, yr.).....

November 20, 1871

6.(c) If alive, give age..... 64 years

8. AGE: Years.....

73

Months.....

7

Days.....

17

It less than one day

hrs.

min.

9. Birthplace.....

Newark, W. Va. Co. Md.

(Town, county, and state)

10. Usual occupation.....

Farmer.

11. Industry or business

12. Name..... William Z. Powell.

13. Birthplace..... Newark, W. Va. Co. Md.

14. Maiden name.....

Mamie Jackson

15. Birthplace.....

Md.

16. Informant..... Mrs. William Z. Powell.

Address..... Newark Md.

17. Burial.....

Date thereof..... 7/10/1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... DOWNEY Cemetery

Location..... Newark Md.

18. Funeral director..... Anna S. Burbage

Address..... Berlin Md.

19. Date rec'd by registrar.....

19. 7/10/45

Registrar.....

(Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Worcester

City or town..... Newark (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7/7 1945 at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/6 1945 to 7/7 1945

and that I last saw him alive on 7/7 1945

Immediate cause of death.....

Hepatitis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... J. H. H.

M. D. or other.....

Address.....

Date signed..... 7/10/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 452

07393

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....

Wisconsin

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

16 months

Hospital, institution, or street address where death occurred:

201 N. Boulevard

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Widowed

6.(b) Name of husband or wife

Ella P. Riall

7. Birth date of deceased (mo., day, yr.)

Dec 15, 1857

8. AGE:

Years Months Days If less than one day

87 6 21 hrs. min.

9. Birthplace

Wisconsin Wisconsin, Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

John Riall

FATHER

12. Name

John Riall

13. Birthplace

Wisconsin, Md

MOTHER

14. Maiden name

Sarah Langherty

15. Birthplace

Wisconsin, Md

16. Informant

Pauline Riall

Address

Salisbury, Md

17. (Burial, cremation, or removal. Which?)

Burial Date thereof 7/8/45

(month) (day) (year)

Cemetery or crematory

St. Mary Cemetery

Location

Wisconsin, Md

18. Funeral director

The Hill & Johnson

Address

Salisbury, Md

19. (Date rec'd by registrar)

7/8/45 Salazar J. Johnson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Wisconsin

City or town.....

Wisconsin

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6 1945 at 10 M

21. I CERTIFY the death occurred on the date above stated; that I attended deceased from

1943 to July 6 1945

and that I last saw h. b. alive on July 6 1945

Immediate cause of death

Exhaustion of power of

DURATION

3 yrs.

Due to

Due to

Other conditions

Hematuria when

3 weeks

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

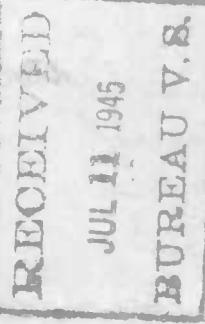
23. SIGNATURE

LaPademarier MP

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

07394

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico CoCity or town Salisbury Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 mo 12 daysHospital, institution, or street address where death occurred:
E.S. & B. Same TownHow long in hospital or institution? 1 mo 12 days

3. (a) FULL NAME

Elonne May Richardson4. Sex Female 5. Color or race White widow 6. (a) Single, married, widowed, or divorced6. (b) Name of husband or wife Geo. Richardson7. Birth date of deceased (mo., day, yr.) May 22, 1896 6. (c) If alive, give age _____ years8. AGE: Years 49 Months 2 Days 1 If less than one day hrs. _____. min. _____.
_____8. Birthplace Hallwood Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Anne T. Chester13. Birthplace Virginia14. Maiden name Anne Murray15. Birthplace Virginia16. Informant deceased on admissionAddress 17. Burial Funeral Date thereof July 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Orange ParkLocation Henry Virginia18. Funeral director John JohnsonAddress Parksley, Va.19. (Date rec'd by registrar) 7/24/45 (Date of death) 1945(Signature of Registrar) Harriet J. Johnson

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

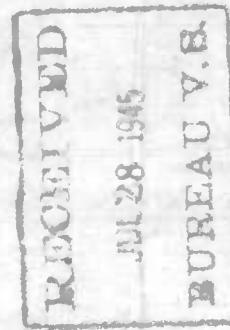
20. DATE OF DEATH July 23 1945 at 6 A.M. P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6.11.145 to 7.23.145 19. and that I last saw her alive on 7.23.145 19.Immediate cause of death Longer time Cerebral Compensation DURATION
unknown 2 monthsDue to Rheumatic insufficiency and metral stenosis unknownDue to Rheumatic heart disease unknownOther conditions unknown

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results Date of

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of Injury Injured at work? 23. SIGNATURE Paul Cohen M.D. M. D. or other Address Salisbury Date signed 7/24/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B.P.

0739:

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County.....

Near Mandeville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 years

Hospital, Institution, or street address where death occurred:.....

Now long in hospital or institution?.....

3. (a) FULL NAME

George H. Riggan

4. Sex

m

5. Color of face

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Kate Riggan

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... 56 years

Oct 4 1878

8. AGE: Years

66

8

Months

Days

It less than one day

hrs.

min.

9. Birthplace.....

Tice, Md

(Town, county, and state)

10. Usual occupation.....

Farming

11. Industry or business

George H. Riggan

FATHER

12. Name.....

Roxie A. Swilley

MOTHER

13. Birthplace

Md

14. Maiden name.....

Mrs. Edward Bennett

15. Birthplace

Md

16. Informant.....

Mrs. Edward Bennett

Address

Mandeville, Md.

17. (Burial, cremation, or removal place?)

Burial Date thereof..... 7 6 1945

(month)

(day)

(year)

Cemetery or crematory.....

Atheel

Location.....

Governor Bros

16. Funeral director.....

H. H. Robertson

Address

7645 Sharpstown Rd

19.

7/6/45

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Shenandoah

City or town.....

Mandeville

Md

RD

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

213-24-0261

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/4

1945 et 1-45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 30th 1945 to July 30th 1945 end that I last saw h. in alive on July 3rd 1945

Immediate cause of death.....

Cerebral Hemorrhage

Due to.....

Due to.....

Other conditions.....

Classic Neuritis

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury

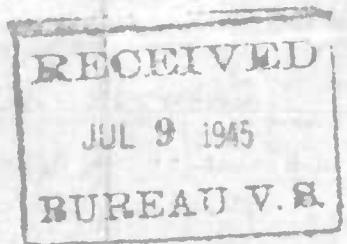
Injured at work?

23. SIGNATURE

M. D. Emrich

Address.....

William Emrich
4 Elmer Rd. Date signed July 4 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 176

07396

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Robinson, Mr Charles

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased

(mo., day, yr.)

6. (c) If alive, give age

years

1900

8. AGE:

Years

Months

Days

If less than one day

45-

.....hrs.

.....min.

9. Birthplace

(Town, county, and state)

Sharptown, Wicomico Md

10. Usual occupation

11. Industry or business

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal; Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date read by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Dorchester

City or town

Rhode Island Rd. P.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21 1945 at 12²⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 21 1945 to July 21 1945

and that I last saw h. I was alive on July 21 1945

Immediate cause of death

Shock & Hemorrhage

DURATION

1 hr

Due to

Fracture of rt thigh
Comp fracture of femur and tibia

2 hrs

Date of Fracture left elbow

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

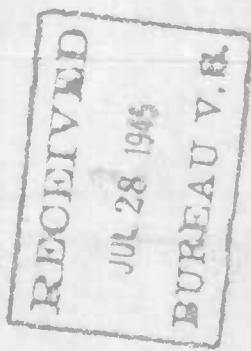
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-20-45Where did injury occur? Farm - Sharptown County Sussex State DelInjured at home, farm, industry, public place (where?) BedroomMeans of Injury Riding Bicycle Injured at work? Nostruck by carpedestrian hit by car23. SIGNATURE J. E. Johnson M. D. or other ExaminerAddress 110 W. Main Street Date signed 7-22-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-28

07397

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County

Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 30 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

3. (a) FULL NAME

Alice Estesbury Sheppard

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female a.a. - married

6. (b) Name of husband or wife

Henry Sheppard

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

about 1868

8. AGE:

Years Months Days If less than one day

about 7 1 hrs. min.

9. Birthplace

Quantico, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Same as above

MOTHER FATHER

12. Name

Robert Bullard

13. Birthplace

Easter Anderson

14. Maiden name

Easter Anderson

15. Birthplace

Quantico, Md.

16. Informant

Henry Sheppard

Address

Salisbury, Md.

17. Burial, cremation, or removal (Which?)

Date thereof July 4, 1945

(month) (day) (year)

Cemetery or crematory

Location Quantico

18. Funeral director

James A. Stewart

Address

Salisbury, Md.

19. (Date rec'd by registrar)

7/2, 1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State no

County Queen Anne's

City or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION) no

2.(a) If veteran, name war

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-1

1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-30, 1945 to 6-30, 1945

1945

and that I last saw her alive on 6-30, 1945

1945

Immediate cause of death Acute Heart Failure (Congestive)

Due to Renal damage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

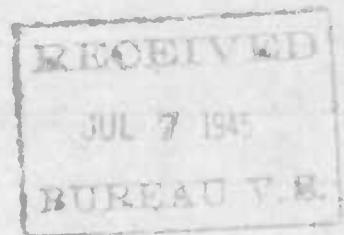
E. P. Purcell, M.D.

M. D. or other

Address

Johnson 200 W. Main St.

Date signed 7-2-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore, Md.

07398

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
 County.....
 City or town..... Salisbury (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs.
 Hospital, Institution, or street address where death occurred:

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... md. County..... Wicomico
 City or town..... Salisbury (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 712 Lake St. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Roxie Leno Smith

3. (b) Social Security Number

4. Sex Female 5. Color or race Caucasian 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife James Smith 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1867

8. AGE: 78 Years 4 Months 17 Days If less than one day
 hrs. min.

9. Birthplace Camden, Del. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housewife

12. Name Benjamin Leboeuf

13. Birthplace Baltimore, Md.

14. Maiden name Amelia Belmore

15. Birthplace Baltimore, Md.

16. Informant Julia Dugay

Address 712 Lake St, Salisbury, Md.

17. (Burial, cremation, or removal, Where?) Burial Date thereof July 15, 1945 (month) (day) (year)

Cemetery or crematory Pattille Chapel

Location Wicomico, Md.

18. Funeral director Mrs. Bashe Watson

Address Salisbury, Md.

19. 7/14/45 (Date rec'd by registrar) 1845 (Social Security No.)

Registrar Johnstone

Date signed 7/12/45

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1945 to July 14, 11, 1945 and that I last saw her alive on July 14, 11, 1945

Immediate cause of death CHRONIC NEPHRITIS DURATION 5 years

Due to:

Due to:

Other conditions Hemoptysis

(Include pregnancy within 3 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIANS: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

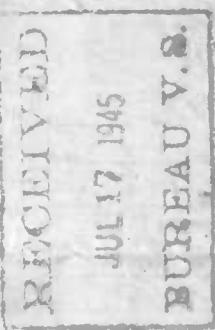
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur D. Brown M. D. or other Johnstone

Address Salisbury, Md. Date signed 7/12/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-120

07399

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....

McComis
near Franklin

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

P.O.

How long in hospital or institution?

3. (a) FULL NAME

Lillie Blanche Taylor

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

White

Married

6. (b) Name of husband or wife

Herman Taylor

6. (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.)

Oct. 2 - 1889

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Baltimore Co. Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

at home

FATHER

William Jefferson Arnett

12. Name

Baltimore Co. Maryland

13. Birthplace

Maryland

MOTHER

Josephine Griffith

14. Maiden name

Baltimore Co. Md.

15. Birthplace

Baltimore Co. Md.

16. Informant

M. Herman Taylor

Address

P.O.#1. Eden Maryland

17. Burial

Burial

Date thereof

July 8-45

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Washington Penn.

Location

Towleek Maryland

18. Funeral director

Holloway & Co. Walter R. Holloway

Address

Salisbury Maryland

19. (Date record by registrar)

19-45

Date record by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

R.D.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 5 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20 1945 to July 5 1945

and that I last saw her alive on July 5 1945

Immediate cause of death

Coronary Thrombosis

Due to

C. S. L. D. Right

Due to

H. C. Left

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Address

M. D. or

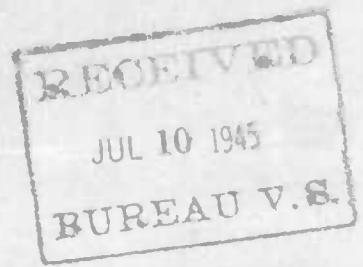
Date signed

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5th

07400

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County..... Wicomico

City or town..... Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 days

Hospital, institution, or street address where death occurred:

Pen. General Hospital

How long in hospital or institution?..... 4 days

3. (a) FULL NAME

Frances J. Townsend

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anna Payne Townsend

7. Birth date of deceased (mo., day, yr.)

April 10, 1875

6. (c) If alive, give age 53 years

8. AGE:

Years
70Months
2Days
22

If less than one day

hrs.

min.

9. Birthplace

Snow Hill, Worcester, Md.

(Town, county, and state)

10. Usual occupation

M.D.

11. Industry or business

Medicine

MOTHER

FATHER

12. Name

Robert Townsend

13. Birthplace

Snow Hill, Md.

14. Maiden name

Susan Bowden

15. Birthplace

Snow Hill, Md.

16. Informant

Anna Payne Townsend

Address

Ocean City, Md.

17. Burial

(Burial, cremation, or removal (which))

Date thereof July 4, 1945

(month) (day) (year)

Cemetery or crematory

M.E. Cemetery

Location

Snow Hill, Md.

18. Funeral director

Anna A. Burbridge

Address

Salisbury, Md.

19. Date rec'd by registrar

1945

1946

Classified

Death certificate

Serial No.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Worcester

City or town Ocean City, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Balto. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 2d 1945 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 1945, to July 2, 1945

and that I last saw h. small alive on July 2, 1945

Immediate cause of death

Lobar pneumonia

Due to

Due to

Other conditions

Pneumonia of prostate 8 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

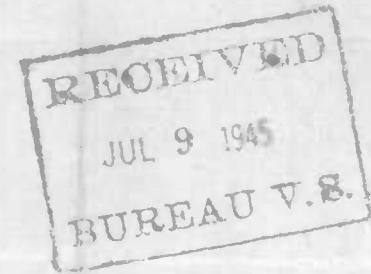
Means of Injury

Injured at work?

23. SIGNATURE

Olaide Parker, M. D. or other

Address Johnson, Salisbury, Md. Date signed 7/21/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

074111

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

4 weeks

How long in hospital or institution?

3. (a) FULL NAME

Tull, Gertrude C.

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife

George Tull

7. Birth date of deceased (mo., day, yr.)

June 15, 1906

6. (c) If alive, give age

40

years

8. AGE:

Years
39Months
1Days
7

If less than one day

hrs.

min.

9. Birthplace

Wicomico County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

Home

11. Industry or business

Gardener

MOTHER FATHER

12. Name

—

Name

Wicomico County, Maryland

13. Birthplace

Wicomico County, Maryland

Name

Theodosia Stanley

14. Maiden name

Wicomico County, Maryland

Name

Serman Cook

16. Informant

Name

Mardela Springs, Maryland, P.T.D.

Address

Burial

Date thereof

July 24, 1945

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery

Location

Wetipquin Cemetery

Name

Wetipquin, Maryland

Address

Funeral director

J. J. Tramptom and Son

Address

Federalsburg, Maryland

Signature

John Rodenbush, M.D.

Address

7/24/45

(Date rec'd by registrar)

19

Signature

John Rodenbush, M.D.

Address

7/22/45

(Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Wicomico

City or town Chaptico - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

219-07-7714

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22, 1945, at 3:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-25, 1945, to 8-22, 1945,

and that I last saw h.e.x. alive on 7-21, 1945.

Immediate cause of death

Myocardial disease
with decompenation

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

John Rodenbush, M.D.

M. D. or other

Address

Date signed

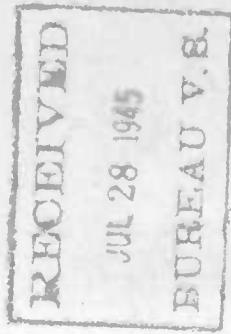
7/22/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct cause of death clearly and legibly, is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-B

07492

CERTIFICATE OF DEATH

Reg. Date No. 333

1. PLACE OF DEATH:

County... Wicomico
City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 daysHospital, Institution, or street address where death occurred:
Peninsula General HospitalHow long in hospital or institution? 6 days

3. (a) FULL NAME

Watson - Mr. Medford S. Sr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MW✓6. (b) Name of husband or wife... Mrs. Mary H. Watson7. Birth date of deceased (mo., day, yr.) November 10, 1858

6. (c) If alive, give age years

8. AGE:

Years 86Months 8Days 9

If less than one day

hrs. min.

9. Birthplace... Roxana, Sussex, Delaware
(Town, county, and state)10. Usual occupation... Retired Funeral Director

11. Industry or business

12. Name... Henry H. Watson13. Birthplace Delaware14. Maiden name... Unknown

15. Birthplace

16. Informant... Mrs. Mary H. WatsonAddress Seaford, Delaware17. Burial Date thereof July 21, 1945
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Old FellowsLocation Seaford, Delaware18. Funeral director... Marguerite H. WatsonAddress Pocomoke City, Md.19. 7/20/45 - Barrett J. Johnson
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Delaware County... SussexCity or town... Seaford
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war. ✓ ✓

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 191945 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1945 to July 19 1945 and that I last saw him alive on July 17 1945.

Immediate cause of death

Uremia

DURATION

5 daysDue to Hypertrophied Prostate
chronic nephritis

6 mos.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide.. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

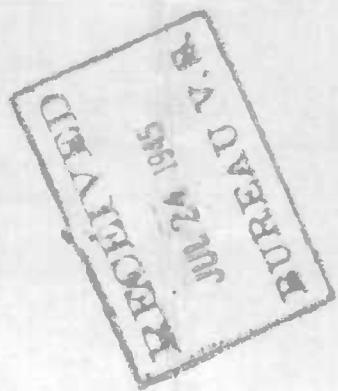
Means of injury

Injured at work?

23. SIGNATURE J. Rademacher M.D.

M. D. or other

Address Salisbury, Md. Date signed 7/19/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 490

07403

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....

City or town.....

wicomico

Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

10 days.

Hospital, Institution, or street address where death occurred:

Salisbury Peninsula Gen Hospt

How long in hospital or institution?.....

3. (a) FULL NAME

Watson Mrs. Viola

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

B. (b) Name of husband or wife.....

John W. Watson

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

January 2 - 1890

Years

Months

Days

Less than one day

55 6 28 hrs. min.

9. Birthplace.....

Poconoske, Worcester County

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Williams Lewis

MOTHER FATHER

12. Name.....

Williams Lewis

13. Birthplace

Md.

14. Maiden name.....

Belle Bunting

15. Birthplace

Md.

16. Informant.....

John Watson

Address

Poconoske Md.

17. Burial, cremation, or removal. Which?

Burial Date thereof Aug 2 1945

(month) (day) (year)

Cemetery or crematory

Hill Hill Baptist

Location

Poconoske Md.

18. Funeral director

Margaret Watson

Address

Poconoske Md.

19. (Date filed by registrar)

7/30/45 Harriet J. Johnson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Worcester

City or town..... Poconoske Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

7/30 1945 at 4 45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/20 1945 to 7/30 1945

and that I last saw her alive on 7/130 1945

Immediate cause of death.....

coronary of artery

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... huge coronary of left artery with metastasis Date of op. 7/16/45

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: U

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

Inhaler M. D. or other

Address..... Date signed 7/20/45

Signature.....

RECEIVED

AUG 3 1945

BUREAU V.S.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and definitely.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 25

117414

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County WicomicoCity or town Manticoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Septemvise

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John S. White

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male col. married

6. (b) Name of husband or wife Victoria White7. Birth date of deceased (mo., day, yr.) Novt 1 Nov 18726. (c) If alive, give age 70 years8. AGE: Years 73 Months Days If less than one day hrs. min. 9. Birthplace Manticoke, Md.
(Town, county, and state)10. Usual occupation Farming

11. Industry or business

FATHER 12. Name John S. White13. Birthplace Manticoke, Md.MOTHER 14. Maiden name Crossilla White15. Birthplace Manticoke, Md.16. Informant Melvin WhiteAddress Manticoke, Md.17. Burial Date thereof July 11, 1945
(Burial, cremation, or removal. Which?)
(month) (day) (year)Cemetery CemeteryLocation Gardenville, Md.18. Funeral director L. G. MessickAddress Bivalve, Md.19. Date reg'd by registrar July 10 1945
R. Bradford Walter

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Manticoke

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945 at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1945 to July 7 1945 and that I last saw alive on July 7 1945

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

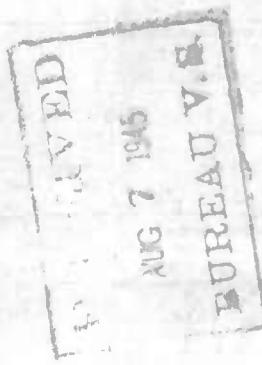
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William E. Smith M. D. or otherAddress Hedges - Md. Date signed July 10 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

07405
Reg. Dist. No. 331

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Wicomico*
 County *Wicomico*
 City or town *St. Michaels*
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *31 yrs.*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?
 3. (a) FULL NAME *James D. Wilson*

4. Sex *Male* 5. Color or race *W.* Married
 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Annie M. Wilson*

7. Birth date of deceased (mo., day, yr.) *January 29, 1867*

8. AGE: Years *78* Months *6* Days *+* If less than one day
 hrs. *+* min. *+*

9. Birthplace *Metipquin, Wicomico, Md.*
(Town, county, and state)

10. Usual occupation *Retired*

11. Industry or business *William Wilson*

FATHER 12. Name *William Wilson*
 13. Birthplace *Metipquin, Md.*

MOTHER 14. Maiden name *Jessie J. Waller*
 15. Birthplace *Metipquin, Md.*

16. Informant *James Wilson*
 Address *St. Michaels, Md.*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *7/3/45*
(month) (day) (year)
 Cemetery or crematory *Wicomico Memorial Park*
 Location *Salisbury, Md.*

18. Funeral director *David T. Burgess*
 Address *St. Michaels, Md.*

19. Date rec'd by registrar *July 29, 1945* M. S. J. Waller
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State *Md.* County *Wicomico*
 City or town *St. Michaels*
(If outside city or town limits, write RURAL and give nearest town)
 Street No. *+*
(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 29, 1945* at *11:15 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *July 1st, 1945* to *July 28th, 1945*
 and that I last saw him *alive* on *July 28th, 1945*

Immediate cause of death *Cerebral Hemorrhage*

DURATION

Due to:

Due to:

Other conditions *arteriosclerosis*

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE *William E. Wilson*
 M. D. or other
 Address *St. Michaels, Md.* Date signed *July 29th*

RECEIVED
AUG 4 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information-carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14-a

07406

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 3 days - 52 min.

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution?... 3 days - 52 min.

3. (a) FULL NAME

Wembrow, Miss Ella Virginia4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1915. 6.(c) If alive, give age ✓ years8. AGE: Years 19 Months 8 Days 12 If less than one day hrs. min.9. Birthplace... Huntingdon, Md.
(Town, county, and state)10. Usual occupation... Secretary11. Industry or business... General Office12. Name... Mabel E. Shortham13. Birthplace... Chesapeake, Va.14. Maiden name... Selma M. Baker15. Birthplace... Chesapeake, Va.16. Informant... Mrs. Lelia B. HindmanAddress... Chesapeake, Va.17. Burial Date thereof... 7/9/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... PineviewLocation... Huntingdon, Md.18. Funeral director... J. de Wolf & Son Co.Address... Salisbury, Md.19. (Date rec'd by registrar) 7/19/45 Barrett S. Johnson
Registrar Local

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Virginia County... CarvermoreCity or town... Chincoteague (If outside city or town limits, write RURAL and give nearest town)Street No... 31 Church St

(If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5 1945 at 8:58 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-2 1945, to 7-5 1945, and that I last saw her alive on 7-3 1945.

Immediate cause of death...

Leukemia

DURATION

3 weeks

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations... none

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE... J. de Wolf & Son Co.

M. D. or other

Address... Chincoteague, Md. Date signed 7-5-45

